Coeur d'Alene Vision Source

Raymond Greene, O.D. Lindsay Hamlin O.D.

WELCOME TO OUR OFFICE

First Name_____ MI_____ Last Name_____ M □ F □

Preferred Name_____ Birth Date_____ Social Security #_____

Parent/Guardian _____ Person responsible for account_____

Mailing Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____ Work Phone_____ Text ok?_____

Best # to reach you_____ E-mail_____

Employer/School_____Occupation_____

Spouse Name_____ Birth Date_____ SS#_____

Who may we thank for referring you? (Please name)_____

Vision Insurance

Insurance Name _____ Subscriber Name _____

Subscriber ID# _____ Subscriber DOB _____

Patient Relationship to insured Self___ Spouse ____ Child _____ Other ____

Medical Insurance

Insurance Name _____Subscriber Name _____

Subscriber ID # _____ Subscriber DOB _____

Patient Relationship to insured Self___ Spouse ____ Child ____ Other ____

Primary Care Physician_____ City and State _____

Pharmacy _____City_____

Current medications (RX or over the counter) List the names of meds including eye drops & vitamins.

_____

_____

Do you have any Allergies to Medications? Yes □ No □

Please List _____

_____

We will bill your insurance for you. If your insurance does not pay as expected, you are responsible for any remaining balance. Signature_____ Date_____

Medical/Ophthalmic History Questionnaire

Please list the primary reason(s) or problem(s) that you would like the Doctor to address at today's exam.

_____

Date of your last eye exam._____

Have you ever had any side effect to dilation drops? Yes ☐ No ☐

Past Eye Surgeries. _____

Past Eye Illness or Injury. _____

Are you *presently* experiencing any of the following;

☐Blurry Vision(distance)	☐Blurry Vision(near)	☐Distorted Vision (Halos)	☐Loss of Side Vision
☐Double Vision	☐Fluctuating Vision	☐Loss Of Vision	☐Drooping Eyelid
☐Foreign Body Sensation	☐Glare/Light Sensitivity	☐Eye Pain/Soreness	☐Tired Eyes
☐Dry Eye	☐Excessive Tearing/Watering	☐Infection of Eye/Lid	☐Mucous Discharge
☐Itchiness	☐Sandy/Gritty Feeling	☐Redness	☐Burning
☐Trouble seeing at night	☐Floaters	☐Flashes of Light	☐Eye turn or crossed

Ocular/Medical History ***Have you been treated for any of the following?***

☐Amblyopia(Lazy Eye)	☐Macular Degeneration	☐Corneal Abrasion	☐Retinal Detachment
☐Cataract	☐Eye Infection	☐Eye Injury	☐Glaucoma
☐Color Blindness	☐Lasik or PRK Procedure	☐Iritis/Uveitis	
☐Diabetic Retinopathy	☐Strabismus(crossed eye/turn)		

General Health Condition

☐Seasonal Allergies	☐Other allergies	☐Muscle Aches	☐Thyroid
☐Sleep irregularities/Weight Loss	☐Appetite	☐Acid Reflux	☐Ulcers
☐Anemia	☐Blood/Lymph	☐Skin Problems	☐Emotional/Psychiatric
☐Urinary Tract	☐Asthma	☐Lung	☐Headache/Migraine
☐Seizures	☐STD/Herpes/HIV	☐Ear/Nose/Throat	☐Arthritis
☐High Blood Pressure	☐Heart	☐High Cholesterol	☐Skin Conditions

☐Diabetes; How long _____

Family/Medical History **Is there any family history of:**

Relationship	***Relationship***
☐ Blindness _____	☐ Cataract _____
☐ Glaucoma_____	☐ Lazy Eye_____
☐ Macular Degeneration_____	☐ Retinal Problems_____
☐ Diabetes_____	☐ Color Blindness_____
☐ Strabismus_____	☐ Other _____

Social History

Do you drink alcohol? Y ___ N ___ If yes, how much/often? ○Occasional ○1 per day ○2-3 day ○4+ day

Do you smoke? Y ____ N ____ If yes, how much/often? ○ Occasional ○1 per day ○2-3 day ○4+ day

VISUAL HISTORY

Do you use a computer? Y___ N___ How many hours/day_____ Distance from computer_____

Do you drive? Y___ N____ Do you have visual difficulty when driving Y____ N____

Do you have problems with night vision? Y____ N____ Do you have problems with glare? Y___N___

SPECTICAL LENS HISTORY

Do you currently wear glasses? Y____ N____ Since_____

Type of glasses: Full Time____ Part Time____ Distance____ Reading_____

Current Glasses Owned**:** Single Vision Distance____ Single Vision Readers____ Bifocals____ Trifocals____

Progressive____ Computer glasses____ Backup pair____ Safety Glasses____

Have you had trouble in the past with glasses? Y____ N____ If yes, explain_____

Do you wear sunglasses? Y____ N____ Are your sunglasses your current prescription? Y____ N____

Contact Lens History

If your not a contact wearer, are you interested in trying contact lenses at this time? Y _____ N _____

If you wore contacts in the past and stopped; what was your reason?_____

Do you currently wear contact lenses? Y___ N ___ Since _____

Type and brand of contact lenses? _____ How many hours a day? _____

How many days of the week? _____Do you sleep in your contacts? Yes ☐ No ☐

How often do you replace your contact lenses? Daily ☐ 2weeks ☐ 1month ☐ Other ☐_____

Do you use contact lens rewetting drops? Y ____ N ____ If so how often? _____

What CL solutions do you use? Optifree ☐ Clear Care ☐ Boston ☐ Other ☐ _____

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT.

	Right/Left		Right/Left		Right/Left
Lens Comfort:	____ ____	Distance Vision:	____ ____	Near Vision:	____ ____

Rate how your contact lenses feel immediately after you put them in. _____

Rate how your contact lenses feel **just before** you take them out._____

Rate how your contact lenses feel just before you replace them with a new pair._____